STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from March 6, 2017 through March 16, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 106. The Stage 2 sample totaled 34 residents. Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN- Licensed Practical Nurse; CNA - Certified Nurse's Aide; RNAC - Registered Nurse Assessment Coordinator; MD - Medical Doctor; MDS - Minimum Data Set Assessment; > - more than; < - less than; = - equal; + - plus Clonazepam - a controlled medication used for nervousness, tension, symptoms of anxiety, seizures and panic disorder; Continence - control of bladder and bowel function; Controlled Substance - a category of behavior-altering or addictive drugs, whose possession and use are restricted by law; Diabetes Mellitus (DM) - disease with high levels of sugar in the blood; Fingerstick - test to determine blood sugar	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/04/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 (glucose); Frequently Incontinent [urine] - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day period; Frequently Incontinent [bowel] - 2 or more episodes of bowel incontinence, but at least one continent BM; GDR (Gradual Dose Reduction) - slowly reducing amount of medication; hyperglycemic-high blood sugar; hypoglycemic-low blood sugar; Incontinence - loss of control of bladder and/or bowel function; Insulin - injected medication to control blood sugar; MAR (Medication Administration Record) - list of daily medications to be administered; Narcotic- a potent drug used to treat severe episodes of pain, often induces sleep, can alter consciousness, and is potentially addictive; Occasionally Incontinent [urine] - less than 7 episodes of incontinence; Occasionally Incontinent [bowel] - one episode of bowel incontinence; Oxycodone - a narcotic pain drug that is subject to abuse and addiction; Pain Scale - rating of pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Pre - before; PRN - as needed; Post - after; Scheduled (or timed) toileting program - fixed times for toileting assistance to help with urinary incontinence; TB-tuberculosis-infectious disease of the lungs; TB skin test- screening test for the presence of tuberculosis;	F 000		

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F 000	Continued From page 2 Vial - a small container, typically cylindrical and made of glass, used especially for holding liquid medicines.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		5/1/17

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F 309	Continued From page 3 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide care and services for two (R75 and R76) out of 34 sampled residents. For R75 the facility did not follow the physicians' plan of care regarding high blood sugars. For R76 interventions were not implemented for unrelieved pain. Findings include: 1. Review of R75's clinical record revealed: 12/3/11 - Admission to facility with multiple diagnoses including diabetes. 1/21/16 - Care plan problem for potential for complications related to diabetes (last reviewed 12/26/16) included the goal that the resident would have no significant complications related to hyper/hypoglycemic episodes. Approaches included to fingersticks as ordered and to report abnormal ranges to the MD as indicated. 7/29/16 - Physicians' order for fingersticks before meals and bedtime with insulin based on fingerstick reading and to call the MD if blood sugar reading was under 60 or over 300. 1/4/17 - Physicians' order for fingerstick once daily (scheduled for 7:30 AM) with no insulin coverage and to call the MD if blood sugar reading was less than 60 or greater than 300. January - March 2017 - R75's physicians' orders and MARs showed: - Fingersticks performed twice a day (7:30 AM and 4:30 PM) after the 1/4/17 order to complete	F 309	F309 #1 A: Resident R75 was not adversely affected by the deficient practice. However there was a potential for adverse effects to the patient because the doctor was not notified of the increased blood sugar per order. B: All diabetic residents with blood sugar parameters have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking corrective actions outlined below in section C. C: Identified nurses were educated to follow medication administration orders including informing MD when blood sugars are above or below parameters. The root cause analysis of this deficient practice was determined to be that nurses did not read the complete instructions in the MAR. Staff nurses will be educated to call the doctor for blood sugars that are above or below parameters as outlined in the MAR. This call, and any new orders will be documented in the patients' MAR/ progress notes. D: DON/designee to audit records of 10% of residents with blood sugar parameters on each unit daily X 3 until we consistently	

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F 309	Continued From page 4 once daily. - Two glucose readings taken at 4:30 PM were over 300: (March 4 = 357 and March 6 = 400). March, 2017 - Review of electronic progress / nursing notes and assessments found no evidence the physician was contacted for insulin orders for the two elevated blood sugar readings. During an interview with E8 (RN, UM) on 3/10/17 at 12:10 PM to determine where the nurse would document physician contact for the high blood sugars, E8 stated the information should be in the progress notes. E8 reviewed R75's progress notes and found no evidence that the order to call the MD for a blood sugar was over 300 was carried out or that insulin orders were obtained. During an interview with E3 (ADON) on 3/10/17 at 12:35 PM E2 reviewed the progress notes and orders and was not able to locate evidence that the MD was notified or that R75 received insulin for these two high blood sugar readings. 2. Review of R76's clinical record revealed: 1/5/17 - Admission to facility with multiple diagnoses including arthritis, chronic pain and recent back surgery. Physicians' orders on admission included oxycodone every 4 hours PRN for severe pain. 1/27/17 - R76's care plan problem for actual pain included the goal that pain will be controlled to a level that is comfortable to the resident. Approaches included to administer pain medications as ordered and report effectiveness and to notify MD of uncontrolled pain. January - March 2017 - R76's MARs showed:	F 309	reach 100% compliance. THEN, DON/designee to audit 10% of residents with blood sugar parameters on each unit weekly X 3 until we consistently reach 100% compliance. THEN DON/ designee to audit 10% of residents with blood sugars parameters monthly X 3 until we reach 100% compliance. At this time the deficient practice will be considered resolved. All audits will be reviewed and discussed at the QA meeting. #2 A: Resident R76 was not adversely affected by the deficient practice. However there was a potential for the resident to experience unmanaged pain because the pre pain score was 8/10 and the post pain score was 4/10. The nurse did not document any follow up or additional interventions taken for the patient when the post pain scale did not meet the acceptable level of pain score of 2/10. B: All residents receiving PRN pain medications have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking corrective actions outlined below in section C. C: Indentified nurses were educated on the follow up, and documentation of pain management including meeting acceptable pain level. The root cause of this deficient practice was determined to	

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F 309	Continued From page 5 - Pain goal = 2 - Resident received 50 doses of the PRN pain medication. - Three doses were not effective: January 10 (8:31 AM) pre and post = 8; February 25 (1:42 PM) pre and post = 8; February 25 (5:55 PM) pre = 8, post = 7). During a resident interview on 3/13/17 at 9:40 AM to discuss pain management in the facility, R76 could not recall when pain was not controlled per MAR documentation. During an interview with E2 (DON) on 3/13/17 at 11:15 AM to review PRN pain medication administrations that were not effective on the MAR E2 said that the nurse may have forgotten documented later in the shift and "maybe the medication was effective later on and not at the time the documentation was done on the MAR." It should be in the progress notes or under observations [assessment section in the computer]. January - February 2017 Progress / nursing notes and observations /assessments documented R76 revealed one PRN pain medication administration was not effective: - 2/25/17 (1:47 PM) progress note: ... was medicated with PRN medicine with positive effect. [It was unclear how the effectiveness was recorded only 5 minutes after the oral PRN pain medication was given]. There was no evidence of further assessment of pain or that the resident received additional intervention, including non-pharmacological actions to aid R76 in reaching the desired pain goal of 2. On 3/13/17 at 1:10 PM the surveyor informed E2	F 309	be that the nurses did not document the follow up actions taken for further pain management. They did not document whether the actions were effective or not. Staff nurses will be educated on pain medication administration, and following up with other interventions e.g. call the doctor for further orders if the current medication is not effective for the residents to achieve a pain level that is acceptable to him or her. This information will be documented in the patients' MAR/ progress notes. D: DON/designee to audit pain medication administration records of 10 % of residents on each unit daily x 3 until we consistently reach 100% compliance. THEN, DON/designee to audit pain medication administration records of 10% of residents on each unit weekly X 3 until we consistently reach 100% compliance. THEN, DON/designee to audit pain medication administration of 10 % of residents monthly X 1 until we consistently reach 100 % compliance. At this time the deficient practice will be considered resolved. All audits will be reviewed and discussed at the QA meeting.	

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F 309	Continued From page 6 about the ineffectiveness for the 2/25/17 (1:42 PM) pain medication administration and offered no explanation. These findings were reviewed with E1 (NHA) and E2 on 3/16/17 at 12:30 PM.	F 309		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific	F 329		5/1/17

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F 329	Continued From page 7 condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide accurate assessment of behavior frequency on quarterly gradual dose reduction meeting worksheet's for one (R96) out of 34 sampled residents whose target behaviors were documented as occurring daily. Findings include: Review of R96's clinical record revealed the following; 6/15/16- Quarterly GDR meeting worksheets for R96 documented four targeted behaviors; 1. Sad, 2. Angry, 3. Crying, 4. Repetitive statements/crying were documented as occurring daily. June 2016- Review of daily behavior monitoring documented target behaviors as occurring behavior 1. 9 days, behavior 2. 4 days, behavior 3. 16 days, and behavior 4. 15 days out of 30 days. Review of R96's progress notes did not reflect a frequency of R96's target behaviors occurring daily. 9/30/16- Quarterly GDR meeting worksheets for R96 documented two targeted behaviors; 1. Sad,	F 329	F329 A: Resident R96 was not adversely affected by the deficient practice. Resident has had these behaviors (crying/yelling) several times a week but was not documented on her behavior sheets. However there was potential for adverse effects if the medications were discontinued because there was not any supporting documentation for its continued usage. B: All residents receiving anti-psychotropic medications have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by corrective actions outlined below in section C. C: Indentified nurses were educated on the correct documentation of behaviors in the patients' record as they occur. Indentified nurses were educated on the correct documentation in the quarterly psychotropic drug reduction sheet. A root cause analysis determined that the behaviors were occurring frequently but	

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F 329	Continued From page 8 2. Crying. The frequency of occurrence section of the worksheet was blank. 1/17/17- Quarterly GDR meeting worksheet for R96 documented four targeted behaviors; 1. Sad, 2. Anxious, 3. Crying, 4. Agitation as occurring daily. January 2017- Review of daily behavior monitoring documented target behaviors as occurring behavior 1. 7 days, behavior 2. 11 days, behavior 3. 7 days, and behavior 4. 8 days out of 31 days. On 3/13/17 at 9:10 AM E10 (RN) and unit manager confirmed that R96 did not have additional behavior monitoring sheets documented by CNA staff. Review of R96's progress notes did not reflect a frequency of R96's target behaviors occurring daily. During an interview on 3/13/17 at 9:19 AM with E10, it was reported that E10 usually fills out the quarterly GDR meeting worksheet, and that R96's daily behavior monitoring sheets for three months are reviewed prior to the filling out of the frequency of targeted behaviors section. During an interview on 3/13/17 at 2:28 PM with E11 (LPN) it was confirmed that E11 documented on R96's 9/30/16 quarterly GDR meeting worksheet which was blank in the frequency of targeted behaviors section. E11 further explained that when completing the quarterly GDR meeting worksheet's, R96's behaviors are reviewed for three months and that the documentation on the daily behavior monitoring "are not as accurately	F 329	the nurses were not documenting them in the MAR. Staff nurses will be educated on the correct documentation of behaviors in the patients' record as they occur. Staff nurses will be educated on the correct documentation of behaviors on the quarterly psychotropic drug reduction record. D: DON/designee to audit documentation on behavior sheets on 10% of the residents on each unit daily x 3 until we consistently reach 100% compliance. THEN, DON/designee to audit documentation on behavior sheets on 10% of the residents on each unit weekly X 3 until we consistently reach 100% compliance. THEN, DON/designee to audit documentation on behavior sheet on 10% of the residents on each unit monthly X 1 month until we consistently reach 100% compliance. At this time the deficient practice will be considered resolved. All audits will be reviewed and discussed at the QA meeting.	

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F 329	Continued From page 9 marked as we would like, and the nurses know the patient and we sit with the patient and review based on what we see of the patient which is not necessarily what is documented." During a second interview on 3/13/17 at 2:44 PM with E10, it was explained that the frequency documented on the quarterly GDR meeting worksheet is derived from the behaviors documented on the daily behavior monitoring. During an interview on 3/13/17 at 2:49 PM with E2 (DON) it was confirmed that the GDR monitoring of target behaviors should reflect data from daily behavior monitoring sheets. The facility failed to provide accurate assessment of behavior frequency on quarterly meeting worksheet for R96, whose target behaviors were documented as occurring daily. However, review of daily behavior monitoring sheets did not indicate the daily frequency of target behaviors. These findings were reviewed with E1 (NHA) and E2 on 3/16/17 at 12:30 PM.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 371		5/1/17

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F 371	Continued From page 10 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to store food in accordance with professional standards for food service safety. Findings include: Observations were made at 11:20 AM 3/13/17 and at 9:14 AM on 3/16/17: -employee personal belongings stored in the dry food storage room Findings were reviewed and confirmed with E9 (cook) at 9:15 AM on 3/16/17. These findings were reviewed with E1 (NHA) and E2 (DON) on 3/16/17 at 12:30 PM.	F 371	F371 1. No negative resident outcomes reported as a result of this deficient practice. Food Service Director immediately corrected the deficient practice. 2. The Food Service Director or designee will in-service all dietary staff on the proper storage of their own personal items i.e. coats and jackets and infection control. 3. Our root cause was due to dietary staff not utilizing facility provided lockers to store their personal belongings i.e. coats and jackets. The Food Service Director or designee will in-service the dietary staff on proper personal belonging storage and infection control.	

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F 371	Continued From page 11	F 371	4. Daily audits will be conducted for one week until 100% consecutive days are achieved then audits will conducted once weekly for two weeks until 100% consecutive days are achieved then once monthly until 100% compliance is achieved. The Food Service Director or Registered Dietitian will conduct audits. Results of the audits will be reported monthly to the Quality Improvement Committee and reviewed for patterns and trends. The QA Committee will provide recommendations as necessary to obtain and maintain compliance.	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient	F 431		5/1/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of other facility documents and interview, it was determined that the facility failed to store medications properly to facilitate the safe administration of medications for three (R47, R185 and R82) out of 34 sampled residents. The facility failed to ensure that one out of six	F 431	F431 #1 A: R47 was not adversely affected by this deficient practice. Review of MAR did not show any reports of pain or discomfort. However there was a potential for the	

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	085050	A. BUILDING _____ B. WING _____	C 03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

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F 431	Continued From page 13 medication cart Controlled Substance Record log books were in order and that an account of all controlled drugs was accurately maintained for R47 and R82. The facility failed to ensure that one out of six medication carts were free of expired and/or unlabeled medications (R185's Insulin vial). Findings include: During medication storage inspection of Warner 2's medication cart on 3/13/17 at 11:45 AM with E10 (RN unit manager), the following was revealed: 1. E13 (RN) signed out on the Controlled Substance Record that he removed 2 tablets of a narcotic pain medication (Oxycodone) from the medication cart to give to R47 on 2/10/17 at 7:00 PM. E10 confirmed that there was no documentation in the medical record or Medication Administration Record that R47 received this medication or that R47 had any complaint of pain. E10 stated that E13 is no longer employed at the facility. 2. A Controlled Substance Record sheet had no label or written information of what medication, dose, order or which resident was receiving the controlled medication, but 10 doses of this medication had been removed from the cart and given to a resident between 3/4/17 and 3/13/17. E10 was able to determine that this sheet was for Clonazepam for R82 and wrote the missing information on the sheet. The facility's policy (dated February 2015) states a Controlled Substance Record sheet is needed for every controlled medication and should include: name of the resident, prescription number, name, strength and dosage form, date received, quantity received and name of the person receiving the	F 431	resident to receive additional medications because the administration of the medication was not documented on the EMAR. E13 (RN) is no longer employed by the facility. B: All residents receiving PRN pain medications have the potential to be affected by this deficient practice. Future residents will be protected by this deficient practice by the corrective action outlined below in section C. C: Staff nurses will be educated on the correct documentation of the removal of narcotic pain medications from the log, and documentation on the EMAR when the medication is administered to the resident. D: DON/designee to audit 10% of PRN narcotic pain medication removal from the resident narcotic log and documentation of the medications on each unit until we are consistently 100% compliance X 3 days. THEN, DON/designee to audit 10% of PRN narcotic pain medication removal from the log and documentation of the medications on each unit until we are consistently 100% compliance x 3 weekly. THEN, DON / designee to audit 10% of PRN narcotic pain medication removal from the log and documentation on the EMAR on each unit until we are 100% compliance x 1 month. At this time the deficient practice will be considered resolved. All audits will be reviewed and discussed at the QA meeting.	

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F 431	Continued From page 14 medication supply. 3. A vial of Insulin was found on the medication cart that had no label to indicate the dose or frequency (per facility policy) and no date as to when it was opened. Only R185's last name was written on the opened box that the vial was in. E10 stated that this insulin must have been sent from the hospital when R185 was admitted to the facility and confirmed that this vial of insulin should not have been on the cart and was in violation of the facility's policy on "Medications received from home or hospital" (dated 5/10/16) because it had not been verified by the facility Pharmacist and had an appropriate label applied. During an interview with E2 (DON) on 3/15/17 at 2:40 PM, the above findings were confirmed. These findings were reviewed with E1 (NHA) and E2 on 3/16/17 at 12:30 PM.	F 431	F 431 #2 A: R82 was not adversely affected by this practice. However there was a potential for the missed medications because the residents' medication log was not correctly labeled with her indentifying information. B: All residents receiving controlled substances have the potential to be adversely affected by this deficient practice. Future residents will be protected by this deficient practice by taking the corrective actions outlined below in section C. C: The indentified controlled substance record log was immediately updated with the resident is information upon discovery. A root cause analysis determined that this page was page 2 of 2 of the controlled medication log. The nurse failed to update the second sheet with the patient is information prior to using it. Staff nurses will be educated on correctly updating of residents controlled substance record logs with the prescription number, name, strength and dosage form, date received, quantity received and the name of the person receiving the medication supply. D: DON/designee to audit controlled substance log of 10% of residents on each unit daily x 3 until we consistently reach 100% compliance. THEN, DON /designee to audit controlled substance log of 10% of residents weekly X 3 until	

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F 431	Continued From page 15	F 431	we consistently reach 100% compliance. THEN, DON/designee to audit 10% of controlled substance log monthly X 1 until we consistently reach 100% compliance. At this time the deficient practice will be considered resolved. All audits will be reviewed and discussed at the QA meeting. F 431 #3 A: R185 was not adversely affected by the deficient practice. However there was a potential for the resident to receive outdated medication because the vial was not properly labeled with residents' name, date opened or dosage of medication to be administered. This medication was immediately removed from the cart upon discovery. B: All residents who have been hospitalized have the potential to be adversely affected by the deficient practice when medications are not properly indentified with the resident□s name, prescriber□s name, date opened, and dosage of medication to be administered. Future residents will be protected from this deficient practice by taking corrective actions outlined below in section C. C: Staff nurses will be educated that all medications not having proper patient identification should be removed from the medication carts immediately. A root cause analysis determined that this	

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F 431	Continued From page 16	F 431	medication was sent to the facility with the resident from the hospital from her recent hospitalization. Medications brought from the home or the hospital should be verified by the pharmacist, and have an appropriate label including the patient's name, prescriber's name ,date opened, and dosage of medication to be administered placed on them. D: Don/designee to audit medication carts on each unit weekly x 3 for correct labeling/identification of medications until we reach 100% compliance. THEN, DON /designee to audit medication carts on each unit monthly X 3 for correct labeling/identification if medications until we reach 100% compliance. At this time the deficient practice will be considered resolved. All audits will be reviewed and discussed at the QA meeting.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment	F 441		5/1/17

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F 441	Continued From page 17 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified	F 441		

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F 441	Continued From page 18 under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that for one (R93) out of 34 sampled residents the facility failed to maintain an infection control program by obtaining a chest x-ray or TB test results from a prior facility when the resident refused the TB skin test. Findings include: Facility policy entitled Tuberculosis Prevention and Control (effective 4/29/16) included: - Skin tests should be administered to new residents ... unless they have documentation of a previous positive reaction. - A two-step procedure is advisable for the initial testing of residents ... to establish a reliable baseline. - There was no instruction in the policy regarding the procedure for when a resident refuses TB skin testing. Review of R93's clinical record revealed: 12/12/16 - Admission to the facility for rehabilitation after hospitalization. December 2017 MAR - R93 refused the TB skin tests on December 12 and 19.	F 441	F441 A: Resident R93 was not adversely affected by the deficient practice. Resident has since discharged from facility. However there was a potential for this resident, and other residents to be adversely affected because of this deficient practice. B: All residents who refused to have a TB skin test done have the potential to be adversely affected by this deficient practice. Future residents will be protected from this deficient practice by taking corrective actions outlined below in section C. C: Root cause analysis determined that the nurse did not order a chest x-ray when the resident refused to have the TB skin test administered. Staff nurses will be educated to inform the physician when a resident has refused a TB skin test. Staff nurses will request a chest x-ray to check for possible TB. The records of the chest x-ray will be kept in the patient records.	

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F 441	Continued From page 19 December 2017 - Review of physicians' orders, physician notes and progress notes found no evidence that the physician was notified of the refusal, that documentation of TB test results from the prior facility or that a chest x-ray was completed / obtained. 3/10/17 (10:00 AM) - R93 discharged from facility. During an interview with E3 (ADON) on 3/10/17 at 2:40 PM to discuss the process for TB testing when a resident refuses the skin test, E3 stated that a chest x-ray should be done. E3 added that sometimes the resident would refuse the x-ray and accept the skin test. E3 checked the computer looking at the R93's MAR, physicians' orders and progress notes and did not find evidence that a chest ray was performed at the time of the TB skin testing refusal. E3 stated that the resident was at a sister facility prior to the hospitalization. 3/10/17 (3:15 PM) - E3 provided a copy of the November 2016 MAR from the other facility showing two TB skin test administrations and the result of the second one, which was negative. The facility failed to ensure R93 was screened for TB or obtained results from a previous facility until after the resident was discharged, after a 3 month length of stay. These findings were reviewed with E1 (NHA) and E2 (DON) on 3/16/17 at 12:30 PM.	F 441	D: DON/designee to audit TB testing administration to all new residents on each unit weekly X 3 until we reach 100% compliance. THEN, DON/designee to audit all new residents on each unit monthly X 3 until we reach 100% compliance. At this time the deficient practice will be considered resolved. All audits will be reviewed and discussed at the QA meeting.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Broadmeadow

DATE SURVEY COMPLETED: March 16, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from March 6, 2017 through March 16, 2017. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 106. The Stage 2 sample totaled 34 residents **Regulations for Skilled and Intermediate Care Facilities**		
3201 **3201.1.0** **3201.1.2**	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 16, 2017, F0272, F0278, F0309, F0329, F0371, F0431, F0441	Cross Refer F0272, F0278, F0309, F0329, F0371, F0431, F0441	5/1/17

Revised

Provider's Signature [signature] NHA Title Administrator Date 4-10-17